STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N087067	A. BUILDING: _____ B. WING _____	12/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVITA SENIOR LIVING AT ROLLING HILLS	629 SOUTH MAIZE COURT WICHITA, KS 67209

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of a resurvey with investigation of complaint #84254 of the above assisted living facility on 11/18/15, 11/19/15, 11/23/15, 11/24/15, 11/25/15, 11/30/15, 12/1/15, and 12/2/15. Revised 2567 mailed to facility 12/9/15. 2nd revision mailed 12/17/15.	S 000		
S3028 SS=E	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation.	S3028		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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S3028	Continued From page 1 This REQUIREMENT is not met as evidenced by: KAR 26-41-101(f)(3)(A) The facility identified a census of 94 residents. The sample included 6 residents. Based on record review and interview for 3 (#444, #777, and #555) of 6 residents sampled, the administrator failed to report to the department within 24 hours and immediately initiate an investigation when a staff member found a cognitively impaired resident on the floor in order to rule out abuse and /or neglect. Findings included: - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia with behavioral disturbance, dysphagia, and hypertension. The record contained functional capacity screens dated 10/4/13, 12/24/13, 9/14/14, and 11/18/15 that indicated the resident experienced impaired short term memory, decision making and memory recall. The functional capacity screens dated 12/23/13, 9/14/14, and 11/18/15 indicated the resident was at risk for falls. The progress notes contained the following entries when a staff member found the cognitively impaired resident on the floor and entry lacked documentation of what caused resident to be on the floor: 8/25/14 resident found on floor of room at 12:00 a.m. Unknown how resident came to be on floor. Resident had 1/2 inch skin tear to left cheek and eyeglasses were broken.	S3028		

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S3028	Continued From page 2 8/30/14 at 9:48 p.m. resident found on floor in room with large skin tear to right elbow, unable to approximate skin edges, resident sent to the emergency room. 9/2/14 at 2:23 a.m. that certified staff member found resident on floor between bed and window. 9/27/14 at 4:20 p.m. another resident reported this resident on floor in dining room. 1/9/15 at 8:36 p.m. Staff member heard resident fall in room. 2/3/15 at 2:01 a.m. resident sitting on floor outside of room. 2/25/15 at 4:06 p.m. resident found lying face down by recliner in lounge area. Swelling to left cheek and eyebrow area, 2 lacerations on lower lip, and large hematoma inside lower lip. 3/15/15 at 10:04 p.m. heard resident fall in room. Found resident on floor with glass items beside resident and clothes hanging over walker. Superficial skin tear to right elbow. 3/20/15 at 4:01 p.m. found on floor in dining room with bump to head. 4/13/15 at 9:15 a.m. resident found on floor in front of closet by the exit door. Resident unable to describe incident. Skin tear to left wrist. 4/21/15 at 7:15 p.m. nurse found resident on floor inside room lying on abdomen with walker to left side and eyeglasses on right side on floor. Resident had a large bleeding hematoma to left side of face and eye, sclera to left eye red and swollen. Sent to the emergency room and found	S3028		

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S3028	Continued From page 3	S3028		

to have concussion, facial laceration, fracture of maxillary alveolar socket wall, periorbital ecchymosis, and skin tear to right elbow.

4/23/15 at 4:15 p.m. resident on floor in dining room.

4/25/15 at 4:50 p.m. resident on floor in dining room.

5/18/15 at 2:15 p.m. Resident found on floor in bathroom.

6/14/15 at 9:56 p.m. Resident found on floor at 9:15 p.m. by certified staff member.

6/16/15 at 7:10 p.m. certified staff member found resident sitting on floor in front of medication cart.

7/10/15 at 1:41 p.m. staff found resident sitting on floor beside bed.

7/15/15 at 9:49 p.m. resident sitting on floor in room between bed and door. Resident unable to tell what happened.

7/22/15 at 7:40 p.m. found on floor in dining room with walker on top of resident.

10/24/15 at 1:00 a.m. resident found sitting on floor by bed. Resident was last observed at 12:15 a.m. and was asleep in bed.

At 10:45 a.m. on 11/23/15, asked the director of nursing for facility investigation of times staff members found resident on floor and incidents reported to the department.

At 11:45 a.m. on 11/23/15, director of nursing provided 3 facility self-investigations for incidents

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S3028	Continued From page 4	S3028		

on 4/21/15, 9/2/14, and 3/1/14 (witnessed fall resulting a fractured clavicle) involving resident #444.

At 4:30 p.m. on 11/23/15, director of nursing stated he/she did not investigate or report to the department all incidents of staff members finding resident on floor.

The administrator failed to report to the department within 24 hours and immediately initiate an investigation when a staff member found cognitively impaired resident #444 on the floor in order to rule out abuse and /or neglect.

- Record review for resident #777 revealed an admission date of 12/11/13 and diagnoses of dementia, type II diabetes mellitus, and hypertension.

The functional capacity screen dated 1/30/14 and 7/24/14 each indicated the resident was independent with eating; required supervision with bathing, dressing, transferring, and walking; physical assistance with toileting; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short term memory, decision making, and memory recall; experienced impaired vision; utilized a walker or wheelchair for mobility; and was at risk for falls.

The progress notes contained the following entries when a staff member found the cognitively impaired resident on the floor and entry lacked documentation of what caused resident to be on the floor:

1/26/15 at 6:54 a.m. resident found on floor in bathroom doorway. Resident pointed to a picture

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S3028	Continued From page 5 of a person and said they pulled him/her out of bed. 6/28/15 at 4:01 p.m. resident found on floor in lounge area. Large skin tear found above left elbow measuring approximately 7 centimeters by 3.5 centimeters. At 10:45 a.m. on 11/23/15, asked the director of nursing for facility investigation of times staff members found resident on floor and incidents reported to the department. At 4:30 p.m. on 11/23/15, director of nursing stated he/she did not investigate or report to the department all incidents of staff members finding resident on floor. The administrator failed to report to the department within 24 hours and immediately initiate an investigation when a staff member found cognitively impaired resident #777 on the floor in order to rule out abuse and /or neglect. - Record review for resident #555 revealed an admission date of 6/12/15 and diagnoses of dementia, type II diabetes, and hypertension. The functional capacity screen dated 5/22/15 indicated the resident required supervision with eating; physical assistance with bathing, dressing, toileting, transferring, and mobility; unable to manage medications and treatments; frequently incontinent of urine; experienced impaired short term memory, decision making, and memory recall; impaired ability to communicate and understand communication; used a wheelchair for mobility; and was at risk for falls. The progress notes contained the following	S3028		

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S3028	Continued From page 6 entries when a staff member found the cognitively impaired resident on the floor: 8/5/15 at 12:49 p.m. found resident sitting on bathroom floor. When staff member asked resident what happened, resident stated "I'm trying to figure out what to do next." 9/16/15 at 2:59 p.m. resident on floor in front of lift chair. Chair in highest position with chair remote hanging from front of chair. 10/3/15 at 12:50 p.m. resident on floor in front of toilet. Resident said guessed he/she slid off toilet. 11/2/15 at 11:15 a.m. resident on floor in front of lift chair. Lift chair in highest position and chair remote on floor. At 4:00 p.m. on 11/23/15, director of nursing stated did not investigate the times staff found resident on floor. The administrator failed to report to the department within 24 hours and immediately initiate an investigation when a staff member found cognitively impaired resident #555 on the floor in order to rule out abuse and /or neglect.	S3028		
S3081 SS=E	26-41-201 (c) Functional Capacity Screen Reassessment (c) Designated facility staff shall conduct a screening to determine each resident ' s functional capacity according to the following requirements: (1) At least once every 365 days; (2) following any significant change in condition	S3081		

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S3081	Continued From page 7 as defined in K.A.R. 26-39-100; and (3) at least quarterly if the resident receives assistance with eating from a paid nutrition assistant. This REQUIREMENT is not met as evidenced by: KAR 26-41-201(c)(1)(2) The facility identified a census of 94 residents. The sample included 6 residents. Based on record review and interview for 3 (#111, 444, and #777) of 6 residents sampled, the administrator failed to ensure designated staff conducted a functional capacity screen at least once every 365 days and following any significant change in condition to determine each resident's functional capacity. Findings included: - Record review for resident #111 revealed an admit date 3/15/13 with diagnoses of congestive heart failure, chronic obstructive heart disease, sleep apnea, dementia, cardiomyopathy and Parkinson ' s disease. The functional capacity screen dated 6/10/15 (annual) recorded resident #111 was independent with transfer, walking/mobility, eating, cognition, required supervision with bathing, toileting, required physical assistance with dressing, management of medications/treatments, bladder incontinence and experienced falls/unsteadiness. Interview on 11/19/15 at 11:30 a.m. with resident #111 stated, " Staff administer medications, assist with bathing, dressing, toileting that required two staff to assist to get (resident) up	S3081		

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S3081	Continued From page 8	S3081		

from chair. " Resident unable to get up by self and had to have assistance with most care. Resident had a flare up with atrial fibrillation and became weak.

Interview on 11/23/15 at 2:20 p.m. with licensed nurse/director of nursing stated and confirmed resident had a change in condition when returned from hospital on 11/4/15 and did not complete a significant change functional capacity screen.

The administrator failed to ensure designated staff conducted a functional capacity screen when resident #111 experienced a significant change in condition.

- Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia and dysphagia.

The record contained a functional capacity screen dated 9/14/14 and an incomplete functional capacity screen started on 7/10/15.

At 4:00 p.m. on 11/18/15, the director of nursing stated he/she had just conducted a functional capacity screen for the resident. Director of nursing provided a functional capacity screen for resident #444 dated 11/18/15.

The administrator failed to ensure designated staff conducted a functional capacity screen for resident #444 at least once every 365 days.

- Record review for resident #777 revealed an admission date of 12/11/13 and diagnoses of dementia, type II diabetes mellitus, and hypertension.

The record contained a functional capacity screen

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S3081	Continued From page 9 dated 7/24/14. The record lacked a subsequent functional capacity screen within 365 days of the 7/24/14 assessment. At 4:15 p.m. on 11/23/15, the director of nursing confirmed the lack of an annual functional capacity screen. The administrator failed to ensure designated staff conducted a functional capacity screen for resident #777 at least once every 365 days.	S3081		
S3085 SS=E	26-41-202 (a) Negotiated Service Agreement (a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the development of a written negotiated service agreement for each resident, based on the resident ' s functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident ' s legal representative, the case manager, and, if agreed to by the resident or the resident ' s legal representative, the resident ' s family. The negotiated service agreement shall provide the following information: (1) A description of the services the resident will receive; (2) identification of the provider of each service; and (3) identification of each party responsible for payment if outside resources provide a service. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(a)(1)(2)	S3085		

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S3085	Continued From page 10	S3085		

The facility reported a census of 94 residents. The sample included 6 residents. Based on record review and interview for 3 (#444, #777, and #111) of 6 residents sampled, the administrator failed to ensure the development of a written negotiated service agreement (NSA) for each resident, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative that contained a description of services the resident would receive and the provider of each service.

Findings included:

- Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia, dysphagia, and hypertension.

At 4:05 p.m. on 11/18/15, the director of nursing provided a functional capacity screen started on 7/10/15 and finished on 11/18/15 that indicated the resident required physical assistance with bathing, dressing, toileting, transferring, and mobility; was unable to perform management of medications and treatments; frequently incontinent of urine; experienced impaired short term memory, long term memory, decision making, and memory recall; was unable to understand communication or to communicate verbally; used a wheelchair for mobility; and was at risk for falls. The functional capacity screen documented the name of a hospice under the therapy/treatment section of the form.

At 3:40 p.m. on 11/18/15, director of nursing provided an NSA for resident #444 dated 11/18/15. Director of nursing stated he/she just now completed the NSA. Review of the document revealed facility staff members

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S3085	Continued From page 11 provided physical assistance with all activities of daily living, feeding assistance of ground texture foods and honey-thickened liquids, management of medications and treatments, and incontinence care. The NSA documented the resident received services from an outside hospice provider. The NSA lacked a description of services provided to the resident by hospice. The NSA lacked documentation of collaboration with the resident's family member or legal representative in the development of the NSA. At 9:30 a.m. on 11/19/15, certified staff member B stated a hospice aide assisted the resident with bathing 2 to 3 times a week and on those days the hospice aide fed the resident lunch. During an interview at 4:20 p.m. on 11/23/15, the director of nursing stated hospice provided incontinence supplies, an aide provided bathing assistance and feeding assistance, and a nurse provided nursing assessments. Director of nursing confirmed the NSA lacked a description of services provided by hospice. Director of nursing stated he/she did not collaborate with the resident's family member in the development of the NSA. The administrator failed to ensure the development of a written NSA for resident #444, based on the resident's functional capacity screening, service needs, and preferences, in collaboration with the resident or the resident's legal representative that contained a description of services the resident would receive and the provider of each service. - Record review for resident #777 revealed an admission date of 12/11/13 and diagnoses of dementia and type II diabetes.	S3085		

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S3085	Continued From page 12 The functional capacity screen dated 7/24/14 indicated the resident was independent with eating; required supervision with bathing, dressing, transferring, and walking; required physical assistance with toileting; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short-term memory, decision making, and memory recall; was at risk for falls; experienced impaired vision; and utilized a walker or wheelchair for mobility. The record contained an NSA dated 5/29/15 that documented facility staff members provided assistance with activities of daily living and management of medications and treatments. The NSA contained the name of a hospice provider as an outside agency providing services. The NSA lacked a description of services provided by hospice. At 9:30 a.m. on 11/19/15, certified staff member B stated a hospice aide provided bathing assistance to the resident. During an interview at 4:12 p.m. on 11/23/15, director of nursing stated a hospice nurse performed nursing assessments but did not know what the hospice aide did for the resident. Director of nursing confirmed the NSA lacked a description of services provided to the resident by hospice. The administrator failed to ensure the development of a written NSA for resident #777, based on the resident's functional capacity screening, service needs, and preferences that contained a description of services the resident would receive from hospice.	S3085		

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S3085	Continued From page 13 - Record review for resident #111 revealed an admit date of 3/5/15 with diagnoses of dementia, congestive heart failure, anemia, chronic obstructive pulmonary disease, hypertension, sleep apnea, cardiomyopathy and Parkinson ' s. The functional capacity screen dated 6/10/15 (annual) recorded resident #111 was independent with transfer, walking/mobility, eating, cognition, required supervision with bathing, toileting, required physical assistance with dressing, management of medications/treatments, bladder incontinence and experienced falls/unsteadiness. The Negotiated Service Agreement (NSA) dated 6-1-15 recorded resident required assist with bathing, dressing, transfer, monitor vital signs, oxygen management, and weight management. The NSA lacked a description of services for hospice care. The record contained a written physician order for hospice care services dated 11/10/15. Interview on 11/19/15 at 11:30 a.m. with resident #111 stated, " Hospice nurses/aides take care of him/her and the nurses change dressing on left shin. Hospice care started a few weeks ago. " Interview on 11/23/15 at 2:20 p.m. with director of nurses stated and confirmed the NSA lacked a description of services provided by hospice. The administrator failed to ensure the development of a written NSA for resident #111, based on the resident's functional capacity screening, service needs, and preferences that contained a description of services the resident	S3085		

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S3085	Continued From page 14 would receive from hospice.	S3085		
S3101 SS=E	26-41-202 (h) NSA Signatures (h) Each individual involved in the development of the negotiated service agreement shall sign the agreement. The administrator or operator shall ensure that a copy of the initial agreement and any subsequent revisions are provided to the resident or the resident's legal representative. This REQUIREMENT is not met as evidenced by: KAR 26-41-202(h) The facility reported a census of 94 residents. The sample included 6 residents. Based on record review and interview for 3 (#777, #555, and #111) of 6 residents sampled, the administrator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement. Findings included: - Record review for resident #777 revealed an admission date of 12/11/13. The negotiated service agreement dated 5/29/15 lacked the signature of the facility representative, licensed nurse, and the resident's family member or representative. - Record review for resident #555 revealed an admission date of 6/12/15. The negotiated service agreement dated 6/15/15 lacked the signature of the facility representative, licensed nurse, and the resident's family member or	S3101		

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S3101	Continued From page 15 representative. - Record review for resident #111 revealed an admission date of 3/5/13 and diagnoses congestive heart failure, dementia, anemia, Parkinson's disease, cardiomyopathy, and chronic obstructive pulmonary disease. The negotiated service agreement dated 6/1/15 lacked the signature of the facility representative, licensed nurse, and the resident's family member or representative. The administrator failed to ensure each individual involved in the development of the negotiated service agreement signed the agreement.	S3101		
S3155 SS=E	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility identified a census of 94 residents. The sample included 6 residents. Based on record review, interview, and observation for 3 (#333, #777, and #444) of 6 residents sampled, the administrator failed to ensure a licensed	S3155		

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nurse provided and coordinated the provision of necessary health care services that met the needs of each resident and were in accordance with the functional capacity screening and the negotiated service agreement.

Findings included:

- Record review for resident #333 revealed an admit date of 6/18/13 with diagnoses of Parkinson's, depression, and anemia.

The functional capacity screens dated 2/13/14 and 9/14/14 recorded resident required supervision with toileting, transfer, walking/mobility, eating, bladder incontinence, required physical assistance with bathing, dressing, communication sometimes understood, unable to manage medications/treatments, cognition recorded difficulty with decision making, experienced impaired decision making, impaired vision, hearing, and experienced falls/unsteadiness.

The negotiated service agreement (NSA)/health care service plan (HCSP) dated 1/30/14 recorded resident #333 required physical assistance with bathing, dressing, toileting, nursing supervision related to skilled rehab stay and fall with injury in last 3 months. Remind resident to speak slow and loud related to speech deficit. Resident uses a four wheeled walker and wheelchair for long distances. Physical therapy/Occupational therapy (PT/OT) recommended resident to use wheelchair for most ambulation needs. Resident continues to be impulsive, with poor decision making and choosing not to request help with transfers. Staff to continue to encourage and offer assistance for resident safety. Encourage to

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lock wheelchair brakes when standing and to ask for assistance when things are out of reach. Parkinson ' s continues to worsen, family and staff trying to keep room organized and picked up to prevent falls and reaching to floor.

Additions to NSA/HCSP included:
3/24/14 housekeeping to clean room at least 3 times a week due to clutter. Resident educated on fall risk and how to prevent.

6/22/14 needs reminders and encouraged to ask for assistance to allow staff to pick up room. Resident fell in commons area after walking with walker and shuffled gait caused fall. Encourage to use wheelchair.

8/5/14 staff to assist with tying shoes when are untied, encourage resident to keep bottom as far back in chair as possible. Resident continued to ambulate independently with walker. Encourage to use wheelchair.

8/20/14 encourage to slow down and think about stepping high. Resident not using walker in room. Staff still attempting to keep room free of clutter, very difficult and resident encouraged to use wheelchair.

The progress notes recorded 11 falls between 2/24/14 and 9/14/14.

The progress notes recorded additional falls on the following dates:
10/17/14 at 3:15 p.m. certified staff called nurse to room. Resident was on the floor in bedroom with dresser on top of him/her and the TV just above his/her head. Dresser removed off resident who was lying flat on stomach, face, with legs/arms to sides. Resident stated was walking

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S3155	Continued From page 18 from couch to bed without walker , lost balance grabbing the dresser, then fell with everything landing on top of him/her. Resident complained of discomfort to head and lower back area where hit by drawers of the dresser. Redness to right backside and right back side of head. Abrasion on right lower back side measuring 5 centimeters (CM) by 2 CM. Just above is a red spot measuring 2 CM by 2 CM. Red area noted under right armpit. 11/1/14 at 2:41 p.m. notified that resident was on the floor in the bar. Resident got up by self. Resident pulled up pants leg and pointed to right knee. Resident able to move knee. Addition to NSA/HCSP 11/3/14 documented family continue to assist with keeping room clear and uncluttered. Family looking for services outside of the facility to come in two times weekly. Staff to assist resident with transfers in and out of chairs. Continue to encourage resident to keep room free of clutter and not to carry items while using walker. The progress notes recorded additional falls on the following dates: 11/11/14 at 4:45 p.m. Resident fell in front office and had gotten self-up. Steri-strips on hand and elbow. 11/13/14 at 3:20 p.m. notified that resident had fallen in the solarium area. Resident stated slid out of chair to floor. No injuries noted. 11/18/14 at 6:27 p.m. notified that resident fell in solarium. Resident was sitting on bottom in front of a bench. Resident stated slid off bench onto the floor. No injuries noted.	S3155		

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S3155	Continued From page 19 12/3/14 at 1:51 p.m. kitchen staff stated that resident was on the floor crawling in hallway toward 1300 hall. Resident got self-up and into wheelchair. Resident stated was bending over to pick up newspaper ads and dropped the paper on floor. Resident landed on hands and knees. 12/3/14 at 3:39 p.m. nurse notified to go to resident ' s room due to fall. Resident was on floor in front of room in hallway. Resident was not using walker or wheelchair. Resident stated was trying to practice walking in the hallway, lost balance and slid back against wall in the hallway landing on bottom. Dark pink mark to back right upper side from rubbing on the wall. 12/10/14 at 12:43 a.m. resident sitting in health services clinic reading a book at the table. Report was being given. Resident bent down to pick up napkin off floor and slid off edge of wheelchair landing on right buttock/hip then to back. Assisted resident up and encourage to lock brake while not moving and to sit way back in wheelchair. 12/17/14 at 5:00 p.m. resident could be seen on the floor resting on entrance to room. Resident stated heard knocking at door and went to check. Opened door and the door flung open and knocked resident down on the floor. Resident not using walker. Observed redness to right shoulder blade and to both knees. 12/23/14 at 11:10 called to commons area. Resident fell out of chair while bending over to pick up glasses . 12/23/14 at 1:28 p.m. called to dining area. Resident was seen by another family member trying to move chair back to sit down for lunch	S3155		

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S3155	Continued From page 20 and fell to floor on bottom. 1/7/15 at 10:54 a.m. resident stated fell at 9:00 pm. last night and didn ' t call anyone. Scraped area on left side of head 2 CM by 2 CM. Area cleansed and left open to air. 1/8/15 at 11:55 a.m. Resident was found on floor on 1300 hallway. Resident was sitting against the wall. Resident stated was trying to turn around to sit on seated walker and fell. Stated hit back against wall. Redness noted to mid back area. 1/28/15 at 11:30 a.m. Resident fell and got self-back into the wheelchair. Resident stated was walking and just fell. Some redness noted to right shoulder along with right hip/leg. Left side noted abrasion 7 CM long by 3 CM wide. Right side 11 CM long by .5 CM wide. 1/29/15 at 10:40 a.m. notified resident on the floor by the pool tables. Resident was getting self-up and into wheelchair. Resident stated slid out of wheelchair to floor. 2/6/15 at 10:42 a.m., resident slid out of wheelchair to floor while visiting with receptionist. 2/13/15 at 6:09 p.m. notified resident had fall in the dining area and witnessed by other residents who stated resident fell to knees and got back up. Resident unable to recall incident. 2/22/15 at 2:39 p.m. Resident slid out of wheelchair onto floor then got back up in chair. 2/26/15 at 4:57 p.m. Resident found to have cut along right eyebrow. Resident stated rolled out of bed and hit head on the floor this morning. Cut 1.5 CM. Area cleansed.	S3155		

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S3155	Continued From page 21 3/14/15 at 5:05 a.m. Nurse notified by another resident that resident(#333) fell outside. Resident lost balance and fell on the concrete. Resident had gotten self-up of ground and was sitting on walker. No new injuries. 3/19/15 at 11:00 a.m. resident reported on the floor by the waterfall. Resident stated was leaning on the large brick island planter in front of waterfall in lobby area. Unable to understand words he/she said. Noted 3 CM by 1 CM skin tear to left outer elbow. Steri strips applied and left open to air. 3/25/15 at 4:07 p.m. notified that resident was on floor in restroom. Resident stated was standing up to do laundry and lost balance in the process 3/26/15 at 7:42 p.m. Resident fell in theater room. Resident situated back in wheelchair. 3/31/15 at 11:58 p.m. Called to room by staff. Resident way lying on floor on back with wheelchair facing him/her at feet. Resident unable to give description of what happened. Level of consciousness lethargic when responding to verbal stimuli. Speech rambling. Assisted to standing with two staff. Hospice nurse sat with resident. The NSA/HCSP lacked revision to address the ongoing risk of falls until 4/2/15: staff to lay towel down on floor when assisting with shower to provide dry surface for resident to step on when exiting the shower. Remind resident to lock wheelchair brakes before standing. Staff to continue to encourage resident to keep room free of clutter. Hospice will provide additional service with activities of daily living and other hospice	S3155		

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S3155	Continued From page 22 appropriate care. Interview on 11/19/15 at 3:10 p.m. with director of nursing stated resident was discharged in April due to active hallucinations and Parkinson s disease getting worse. Resident was disruptive to other residents in the dining room and would go back in the kitchen area. Interview on 11/19/15 at 3:25 p.m. with director of nursing stated did not have any means to track falls or any investigations. The director of nurses stated resident was encourage to sit back further in the wheelchair and stated did not realize resident had that many falls. Met with family on 4/1/15 and hospice informed family resident #333 needed to move to another facility due to increased falls. For resident #333 who experienced twenty-four falls in the 6 months preceding his/her discharge, the licensed nurse failed to provide and coordinate necessary health care services to address the resident ' s risk for falls. - Record review for resident #777 revealed an admission date of 12/11/13 and diagnoses of dementia, type II diabetes mellitus, and hypertension. The functional capacity screens dated 1/30/14 and 7/24/14 each indicated the resident was independent with eating; required supervision with bathing, dressing, transferring, and walking; physical assistance with toileting; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short term memory, decision making, and memory recall; experienced	S3155		

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impaired vision; utilized a walker or wheelchair for mobility; and was at risk for falls.

The negotiated service agreement (NSA) /health care service plan (HCSP) dated 5/29/15 lacked interventions to address the resident's risk for falls.

The progress notes recorded falls on the following dates:

1/24/15 at 5:52 a.m. resident slid off bed while attempting to take medications.

1/26/15 at 6:54 a.m. resident found on floor in bathroom doorway. Resident pointed to a picture of a person and said they pulled him/her out of bed.

1/27/15 at 9:56 p.m. resident found on floor in room between chair and wheelchair. Resident stated he/she was trying to transfer self from chair to wheelchair.

2/3/15 at 11:00 a.m. resident found on floor in dining room. Resident stated he/she slid out of wheelchair.

4/12/15 at 2:34 p.m. certified staff member found resident sitting on floor by bed. Resident stated he/she slid from bed.

4/12/15 at 6:00 p.m. Resident fell in dining room and received a 1 centimeter abrasion to right elbow. Resident stated was trying to walk to another table.

6/28/15 at 4:01 p.m. resident found on floor in lounge area. Large skin tear found above left elbow measuring approximately 7 centimeters by

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S3155	Continued From page 24 3.5 centimeters. At 9:00 a.m. on 11/19/15, observed resident in bed in his/her room with wheelchair and walker beside bed. Resident awake and oriented to self but not time or place. During an interview at 9:30 a.m. on 11/19/15, certified staff B stated resident was independent with ambulation. Certified staff B could not identify any interventions related to resident's risk for falls. Certified staff B stated resident ' s mood had improved recently and had not fallen lately At 4:15 p.m. on 11/23/15, the director of nursing confirmed resident's negotiated service agreement/health care service plan lacked interventions related to the resident's risk for falls. The administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary health care services to address resident #777's risk for falls and unsteadiness. - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia with behavioral disturbance, dysphagia, and hypertension. The record contained a functional capacity screen dated 9/14/14 that indicated the resident was independent with transferring; required supervision with toileting, walking, and eating; physical assistance with bathing and dressing; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short term and long term memory, decision making, and memory recall; had difficulty communicating but could	S3155		

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S3155	Continued From page 25 understand communication; experienced impaired vision; used a walker for mobility; and was at risk for falls. The record indicated on 7/10/15 a functional capacity screen was started but not finished. At 4:00 p.m. on 11/18/15, the director of nursing stated he/she had just conducted a functional capacity screen for the resident. Director of nursing provided a functional capacity screen for resident #444 dated 11/18/15 that indicated resident #444 now required physical assistance with toileting, transferring, mobility, and eating; was frequently incontinent of urine; could not communicate or understand communication; required a wheelchair for mobility; and continued to be at risk for falls. The health care service plan dated 4/22/15 described services to be provided as: Bathing--adjust water and give resident verbal directions to complete shower. Dressing-- staff will set up clothing, observe and give resident verbal cues to dress. Assist if resident having difficulty. Medication and treatment administration. In case of evacuation, resident requires verbal instruction and reassurance. Speech deficit--use visual cues for resident to point at to communicate options. Resident will sometimes write concerns on paper. Assistance with mobility--remind and encourage use of front-wheeled walker when ambulating, provide mobility assistance to and from meals, staff to observe resident with ambulation and notify nurse/medical care provider of changes in gait, balance, and endurance. Meals--set up meal and observe resident. History of falls--Assist mobility with walker if	S3155		

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resident is leaning to the right or gait unsteady; assure room is free of clutter or debris on floor; place walker next to bed at night to encourage resident to use if awakens; use appropriate footwear; increase visual checks of resident during night time hours; offer and assist toileting frequently; assist with getting ready for bed around 9:00 p.m.; increase visual checks when resident in room; keep walker placed close to dining table when resident in dining room.

Review of the progress notes revealed the resident experienced multiple falls since 12/24/13 with 11 falls in the past 6 months.

Progress notes documented the last fall on 10/24/15 at 2:02 a.m. and recorded "Resident is unable to bear any weight which has been normal for (resident)." Entry 10/24/15 at 10:34 a.m. that resident required physical assistance to eat a meal and would not follow verbal cues to feed self.

During an interview at 9:30 a.m. on 11/19/15, certified staff B stated resident required physical assistance to total care with all activities of daily living. Certified staff B confirmed resident had a history of falls but no longer able to walk so falls had decreased. Certified staff B stated interventions to reduce risk for falls when resident was ambulatory staff members made sure resident had walker and checked on resident frequently but now kept resident in commons area for staff members to observe. During interview with certified staff B, observed resident #444 asleep in a recliner in the commons area.

For resident #444, the administrator failed to ensure a licensed nurse provided and coordinated the provision of necessary health

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AVITA SENIOR LIVING AT ROLLING HILLS	629 SOUTH MAIZE COURT WICHITA, KS 67209

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S3155	Continued From page 27 care services to address resident #444's falls, decline in functioning, and change in care needs.	S3155		
S3250 SS=F	26-41-105 (a) Resident Records a) The administrator or operator of each assisted living facility or residential health care facility shall ensure the maintenance of a record for each resident in accordance with accepted professional standards and practices. (1) Designated staff shall maintain the record of each discharged resident who is 18 years of age or older for at least five years after the discharge of the resident. (2) Designated staff shall maintain the record of each discharged resident who is less than 18 years of age for at least five years after the resident reaches 18 years of age or at least five years after the date of discharge, whichever time period is longer. This REQUIREMENT is not met as evidenced by: KAR 26-41-105(a) The facility identified a census of 94 residents. The sample included 6 residents. Based on record review and interview with potential to affect all resident records, the administrator failed to ensure the maintenance of a record in accordance with acceptable standards of practice as evidenced by the dates of health care plan interventions changed to date of the last revision and lack documentation of resident discharge. Findings included:	S3250		

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S3250	Continued From page 28 Review of resident health care service plan showed dates of all health care services following incidents and accidents with the same date. - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses of dementia with behavioral disturbance, dysphagia, and hypertension. The record contained a functional capacity screen dated 9/14/14 that indicated the resident was independent with transferring; required supervision with toileting, walking, and eating; physical assistance with bathing and dressing; unable to perform management of medications and treatments; was usually continent of urine; experienced impaired short term and long term memory, decision making, and memory recall; had difficulty communicating but could understand communication; experienced impaired vision; used a walker for mobility; and was at risk for falls. The record indicated on 7/10/15 a functional capacity screen was started but not finished. At 4:00 p.m. on 11/18/15, the director of nursing stated he/she had just conducted a functional capacity screen for the resident. Director of nursing provided a functional capacity screen for resident #444 dated 11/18/15 that indicated resident #444 now required physical assistance with toileting, transferring, mobility, and eating; was frequently incontinent of urine; could not communicate or understand communication; required a wheelchair for mobility; and continued to be at risk for falls. The health care service plan dated 4/22/15 documented that resident had an unwitnessed fall and listed the following interventions to be	S3250		

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S3250	Continued From page 29 implemented by staff members related to resident's risk for falls : Assist mobility with walker if resident is leaning to the right or gait unsteady. Assure room is free of clutter or debris on floor. Place walker next to bed at night to encourage resident to use if awakens. Resident to use appropriate footwear. Increase visual checks of resident during night time hours. Offer and assist toileting frequently. Assist with getting ready for bed around 9:00 p.m. Increase visual checks when resident in room. Keep walker placed close to dining table when resident in dining room. Each intervention contained "Date initiated: 4/22/15." Review of the resident's previous negotiated service agreements/health care service plans revealed the following: Offer and assist with toileting frequently initiated on 2/4/14 Assist mobility with walker if resident is leaning to the right or gait unsteady initiated on 3/4/14. Assure room is free of clutter or debris on floor initiated on 5/20/14. Increase visual checks when resident in room initiated on 6/16/14. Place walker next to bed at night to encourage resident to use if awakens initiated on 9/24/14. Increase visual checks of resident during night time hours initiated on 9/29/14. Assist with getting ready for bed around 9:00 p.m. initiated on 9/29/14. Keep walker placed close to dining table when resident in dining room initiated on 9/29/14. The current negotiated service agreement/health care service plan dated 4/22/15 lacked	S3250		

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S3250	Continued From page 30	S3250		

documentation of the original date each intervention. When changes are made to computerized form, the dates of all information are revised to the date of the change.

For resident #444 and with the potential to affect all residents, the administrator failed to ensure the maintenance of a record in accordance with acceptable standards of practice.

Review of records for discharged residents identified a lack of documentation of of what time resident moved, who resident left with, medications sent with resident, where resident transferred to and physician order for transfer/discharge.

Interview on 11/19/15 at 3:10 p.m. with director of nursing stated resident discharged to a home plus facility stated there is nurses do not document any discharge notices.

- Record review for resident #333 revealed an admit date of 6/18/13 with diagnoses of Parkinson's, depression, and anemia.

The functional capacity screens dated 2/13/14 and 9/14/14 recorded resident required supervision with toileting, transfer, walking/mobility, eating, bladder incontinence, required physical assistance with bathing, dressing, communication sometimes understood, unable to manage medications/treatments, cognition recorded difficulty with decision making, experienced impaired decision making, impaired vision, hearing, and experienced falls/unsteadiness.

The negotiated service agreement (NSA)/health care service plan (HCSP) dated 1/30/14 recorded

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S3250	Continued From page 31	S3250		

resident #333 required physical assistance with bathing, dressing, toileting, nursing supervision related to skilled rehab stay and fall with injury in last 3 months. Remind resident to speak slow and loud related to speech deficit. Resident uses a four wheeled walker and wheelchair for long distances. Physical therapy/Occupational therapy (PT/OT) recommended resident to use wheelchair for most ambulation needs. Resident continues to be impulsive, with poor decision making and choosing not to request help with transfers. Staff to continue to encourage and offer assistance for resident safety. Encourage to lock wheelchair brakes when standing and to ask for assistance when things are out of reach. Parkinson ' s continues to worsen, family and staff trying to keep room organized and picked up to prevent falls and reaching to floor.

The progress notes recorded the following: 4/3/15 at 9:07 a.m. Resident continues to be of fall follow up. No voiced pain or discomfort noted at this time. Right upper arm skin tear continues to heal. Brown scab remains on right elbow area.

The progress notes from 4/4/15 to 4/5/15 electronic medication administration record (EMAR) recorded, " Resident Moved. "

The progress notes lacked documentation of what time resident moved, who resident left with, medications sent with resident, where resident transferred to and physician order for transfer/discharge.

Interview on 11/19/15 at 3:10 p.m. with director of nursing stated resident discharged to a home plus facility and confirmed the progress notes lacked documentation of discharge for resident #333.

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S3250	Continued From page 32 The administrator failed to ensure the maintenance of a record for discharged residents in accordance with acceptable standards of practice.	S3250		
S3280 SS=F	26-41-104 (d) Disaster and Emergency Preparedness (d) Each administrator or operator shall ensure disaster and emergency preparedness by ensuring the performance of the following: (1) Orientation of new employees at the time of employment to the facility ' s emergency management plan; (2) education of each resident upon admission to the facility regarding emergency procedures; (3) quarterly review of the facility ' s emergency management plan with employees and residents; and (4) an emergency drill, which shall be conducted at least annually with staff and residents. This drill shall include evacuation of the residents to a secure location. This REQUIREMENT is not met as evidenced by: KAR 26-41-104(d)(3) The facility identified a census of 94 residents. The sample included 6 residents. Based on interview and record reviews for all residents, the administrator failed to ensure a quarterly review of the emergency management plan with employees and residents conducted. Findings included:	S3280		

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S3280	Continued From page 33 - Interview on 11/25/15 at 1:25 p.m. with maintenance supervisor provided a disaster planning, evacuation process in-service with employees. Maintenance supervisor stated was not aware of a quarterly review of emergency management plan with residents and employees and confirmed a quarterly review of the emergency management plan not conducted. For all residents and employees, the administrator failed to ensure a quarterly review of the emergency management plan.	S3280		
S3290 SS=E	26-41-206 (a) (b) Dietary Services (a) Provision of dietary services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of dietary services to residents as identified in each resident ' s negotiated service agreement. If the administrator or operator of the facility establishes a contract with another entity to provide or coordinate the provision of dietary services to the residents, the administrator or operator shall ensure that entity ' s compliance with these regulations. (b) Staff. The supervisory responsibility for dietetic services shall be assigned to one employee. (1) A dietetic services supervisor or licensed dietician shall provide scheduled on-site supervision in each facility with 11 or more residents. (2) If a resident ' s negotiated service agreement includes the provision of a therapeutic diet, mechanically altered diet, or thickened consistency of liquids, a medical care provider ' s	S3290		

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S3290	Continued From page 34 order shall be on file in the resident ' s clinical record, and the diet or liquids, or both, shall be prepared according to instructions from a medical care provider or licensed dietitian. This REQUIREMENT is not met as evidenced by: KAR 26-41-206(b)(2) The facility identified a census of 94 residents. The sample included 6 residents. Based on record review and interview for 2 (#444 and #555) of 2 sampled residents and 4 (#800, #801, #802, and #803) of 4 non-sampled residents requiring mechanically altered diets and/or thickened liquids, the administrator failed to ensure the mechanically altered diet and/or thickened liquids were prepared according to instructions from a medical care provider or licensed dietitian. Findings included: - Record review for resident #444 revealed an admission date of 11/4/12 and diagnoses dementia and dysphagia. The functional capacity screen completed 11/18/15 indicated the resident required physical assistance with eating. The record contained a medical care provider's diet order dated 6/27/15 for mechanical soft foods with ground meat and gravy and honey thick liquids. - Record review for resident #555 revealed an admission date of 6/12/15 and diagnoses of dementia and type II diabetes. The functional capacity screen dated 5/22/15 indicated the resident required supervision with eating. The record contained a medical care provider's order	S3290		

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S3290	Continued From page 35 dated 6/11/15 for a carbohydrate controlled diet with ground texture foods. At 2:40 p.m. on 11/23/15, the activity director provided a list of residents that lived in the memory care units that required mechanically altered and/or thickened liquids. The list maintained in the "aide notebook" documented resident # 444 required ground texture foods and honey thick liquids, resident #555 required ground texture foods and regular consistency fluids, resident #800 ground texture foods and regular consistency fluids, resident #801 regular texture foods and honey thick liquids, resident #802 ground texture foods and nectar this fluids, and resident #803 ground texture foods and regular consistency fluids. At 2:55 p.m. on 11/23/15, the dietary manager confirmed the lack of instructions from a medical care provider or licensed dietitian to prepare mechanically altered diets and thickened fluids. For all residents who required a mechanically altered diet, the administrator failed to ensure mechanically altered diets and/or thickened liquids were prepared for residents according to instructions from a medical care provider or licensed dietitian.	S3290		